The Behavior Analyst 1993, 16, 269–270 No. 2 (Fall)

# *Clinical Behavior Analysis*

## Introduction

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As a field, applied behavior analysis has been extraordinarily successful in demonstrating changes in socially relevant behavior. However, as critics point out, applied behavior analysis often tends to focus on such clinical populations as the developmentally disabled, autistic, head injured, and behaviorally disordered in such clinical settings as schools, hospitals, and training institutions. Moreover, the interventions are often effective because a good deal of direct control may be exerted over the contingencies of reinforcement affecting the clinical population.

There are, however, other important clinical settings in which there is comparatively little direct control over contingencies of reinforcement and in which the primary mode of intervention is verbal. I am speaking here of the typical outpatient setting involving a client who visits a thereapist once or twice a week to receive "psychotherapy" or "counseling" concerning the myriad problems that one faces in daily life. Applied behavior analysis is often perceived as having much less to say to clinicians working in these settings. Indeed, many argue that there is a critical gap in the literature available to behavior-analytically oriented clinicians who work with clients suffering from disorders such as depression, anxiety, and interpersonal distress.

Some verbally based interventions that are used in the treatment of the kinds of disorders commonly seen in outpatient settings are classified under the general rubric of "behavior therapy," and many behavior-analytically oriented clinicians have turned to the behavior therapy literature for guidance. As a whole, however, the literature in this field is hardly satisfying. One might reasonably argue that as a field, behavior therapy is in fact philosophically, conceptually, and methodologically alien to behavior analysis. Where behavior analysis is functionalistic, materialistic, nonreductive, and idiographic, behavior therapy is structuralistic, mentalistic, reductive, and nomothetic. To see the basic incompatibilities between the two approaches, one need only observe in the behavior therapy literature the accelerating trend toward cognitive approaches (Dobson, Beamish, & Taylor, 1992), the proliferation of mentalistic theories that appeal to cognitive structures and hypothetical constructs (e.g., self-efficacy) as explanations, and the increasing reliance on statistical inference to demonstrate efficacy. There may very well be disagreement between the two perspectives even on the basic goals of treatment (Dougher, in press; Hayes, 1987). Given the relatively large number of behavior analysts who work in clinical settings, a better alternative would be to develop clinical behavior analysis to the point at which it is in itself a coherent, systematic, and empirically validated clinical approach. The purpose of this series is to take a step in that direction.

The series will be divided into two sections. The first, appearing in this issue, is devoted to conceptual issues in clinical behavior analysis. The second will appear in the next issue and will be concerned with actual applications of clinical behavior-analytic interventions. The papers in the present issue begin with an attempt by Kohlenberg, Tsai, and Dougher to define the critical dimensions of behavior analysis and to articulate its

Thanks are extended to Steve Starin and Art Houts for serving as guest reviewers for some of the papers in this series.

distinction from behavior therapy and other psychotherapies. Following this article, Hayes and Wilson discuss the relevance of verbal events to a behavior-analytic understanding of a number of important clinical issues. In the third paper, Follette, Bach, and Follette explore the question of psychological health or well-being from a behavior-analytic perspective. Finally, Cordova and Koerner discuss behavior-analytically driven alternative approaches to treatment outcome measures and clinical research.

The papers included in this series are intended to (a) describe current and novel efforts to extend the application of behavior analysis to clinical populations and issues that have been traditionally neglected by behavior analysts; (b) explore the implications of contemporary behavior-analytic research, especially in the area of verbal behavior, to clinical issues; and (c) stimulate dialogue and new research efforts on the general topic of clinical behavior analysis. Because the papers are intended to expand current thinking, they may very well engender disagreement and even controversy. As long as they also engender dialogue and research, they will have served their function.

## REFERENCES

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